

GENITO-URINARY ORGANS.

I. Incomplete Paraplegia of the Lower Limbs and Pseudo-Locomotor Ataxia from Phimosis; Operation; Cure. By SOLON CHROMATIANOS (Athens, Greece). The writer records the case of an officer of the Greek cavalry, fifty-eight years of age, of healthy antecedents and with a negative history, who, in consequence of a balanoposthitis, had contracted an extreme phimosis. He treated the disease himself by astringent injections, in consequence of which his prepuce had, six months before, contracted down so as scarcely to admit a pinhead. Nervous symptoms then appeared; a progressive weakness of the lower limbs, dysuria, from accumulation of the urine between the glans and prepuce, which was only to be expelled with violent efforts. This extended into a complete paresis of the sphincter vesicæ, so that his urine dripped continuously day and night. He also presented well-developed ataxic symptoms, as instability of movement, disturbances of insensibility in the soles of the feet, impossibility of walking backward, while, on closing his eyes or in the dark, he would totter. Patellar reflex abolished and a fixed pupil. Urine normal on examination. Circumcision was done, and a large-sized sound introduced with ease. This was removed on the fifth day after the operation. Fifteen days after the vesical disturbance began to improve, and in a month he could retain his urine the entire night, and urinate normally. The ataxic phenomena improved after the vesical symptoms began to become better, and forty days after the operation he departed for Thessaly, where he went on active duty, making long marches without fatigue or any ataxic or paraplegic symptoms becoming manifest. Shortly before his departure he was examined and the patellar reflex found to have reappeared and his pupil to react normally.—*Le Progrès Médical*, No. 15, 1893.

FRANK H. PRITCHARD (Norwalk, Ohio).

II. Catheterization of the Ureters. By H. A. KELLY, M.D. (Baltimore). By catheterization of either ureter we are able to secure, isolated, the urine from the respective kidney of that side,

containing evidence of the disease of the ureter, pelvis of the kidney, or the kidney itself above the catheter, according to the microscopic character of its sediment, associated which the history and physical signs.

The following routine in catheterization should be observed: First, all the urine in the bladder is drawn off and put to one side, then the bladder is distended with 150 to 200 c.c. (about six ounces) of a methyl-blue solution. It is now evident that if the catheter enters the ureter in the catheterization and clear urine is discharged by the catheter it does not come from the bladder. There is one possible source of error—when the lower part of the ureter is so distended that the water from the bladder backs up into it and so escapes through the catheter; this will be obviated by carrying the catheter still higher up.

The usual method of introducing the catheter is by retracting the vaginal wall and introducing the ureteral catheter into the bladder, and turning its point forward and trying to introduce it by observing the play of the point of the catheter over the anterior wall, as it seeks the ureteral orifices in the ureteral folds described by Pawlik in *Langenbeck's Archiv.*, Band XXXIII, Heft 3. The ureters lie a little above or in the upper part of this fold, one or two centimetres to the right and left of the median line.

The urine does not begin to escape from the catheter at once; sometimes it is three or four minutes before beginning. Time must be allowed for it to fill the lumen of the catheter before it begins to run out, and the urine in the catheter must be added to that collected.

The catheter is kept from collecting fluid from the bladder during its introduction into the ureter by coating the metal plug which stops the end with a little vaseline, thus rendering it air-tight. As soon as it is in the ureter the plug is withdrawn.

The urine flows by gushes at intervals of ten or fifteen or thirty seconds. It is evident from this that the urine collects in the pelvis of the kidney, passes into the ureter, and is forced down by a peristaltic wave more or less rhythmic in character. It would appear to

inspection like a little bolus being swallowed. It is thus forced into the bladder in intermittent jets.—*Annals of Gynecology and Pediatrics*, May, 1893.

TUMORS.

Treatment of Nævi by Sublimate Collodion. By Dr. CIESFELD (Barmen, Austria). The writer recommends sublimate collodion (1 : 8) in the treatment of vascular nævi. It acts with certainty, is painless and rapid. No disagreeable side action has been observed. The procedure is as follows: A moderately thick coating is applied over the nævus and 1–2 mm. over on to the surrounding skin. Then blow on the collodion in order to aid its drying, and repeat the procedure once or twice, according to the size. Be careful to see that the patient's friends are cautioned about protecting this coating from any injury, as in washing. In ten to twelve days this falls off and leaves a dry, white, superficial and smooth cicatrix. In case a few groups of vessels remain in the scar, repeat it again until it has completely disappeared. This method is also applicable in larger teleangiectases.—*Erztlicher Praktiker*, No. 13, 1893.

BONES, JOINTS, ORTHOPÆDIC.

I. Treatment of Myelogenous Sarcomata of the Long Bones by Resection. By Dr. NEUMANN (Halle). Neumann presented a woman twenty years of age at the twelfth meeting of the German Surgical Society who had fallen down several steps and received a slight injury of the left knee, which fourteen days later had become more painful, with a tendency to collapse at times. The next year she was able to walk only with the aid of a cane. The physician who treated her made an incision below the patella and proposed amputation, which led her to enter the hospital. This incision, which was seven centimetres in length, and crossed by another of five in length, exposed a dirty, gray, immovable mass that proved to be a giant cell